

M E D I C A L  
A S S I S T A N C E  
E L I G I B I L I T Y

O v e r v i e w

*April 2006*

W a s h i n g t o n   S t a t e   D e p a r t m e n t   o f  
S o c i a l   a n d   H e a l t h   S e r v i c e s  
H e a l t h   a n d   R e c o v e r y   S e r v i c e s   A d m i n i s t r a t i o n

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***NOTE: These are  
guidelines only.  
The Department of  
Social and Health  
Services (DSHS) has  
responsibility for  
making eligibility  
decisions for medical  
benefits.***

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# Overview

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*This information is also available on the HRSA web site at:*

*<http://fortress.wa.gov/dshs/maa/>*

*Click on the heading "Eligibility for Medical Programs".*

*NOTE: These are guidelines only. The Department of Social and Health Services (DSHS) has responsibility for making eligibility decisions for medical benefits.*

*To obtain this publication in alternative format, please contact the Department of Social & Health Services ADA Coordinator.*

## INTRODUCTION & DEFINITIONS

This guide offers an overview of eligibility requirements for medical programs. It does not include all requirements or consider all situations that may arise. Please contact your local Community Services (CSO) or Home and Community Services (HCS) office for information about a specific situation.

Income levels based on Federal Poverty Level (FPL) and Cost of Living Adjustments (COLA) change yearly. This booklet is updated regularly to reflect those changes. The program identifier for the Medical ID Card is shown after each program name on the following pages. For the location of the program identifier on the Medical ID Card, see page 14.

**MEDICAID:** The state and federally funded medical aid program that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

**CATEGORICALLY NEEDY (CN):** The federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for CN only, or may **also** be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CN includes full scope of coverage for pregnant women and children.

**FEE-FOR-SERVICE:** The term used when a client is able to go to get care from doctors and other medical providers who will accept the MAA medical coupon called a Medical Assistance ID card, without membership in a managed care program or health maintenance program.

**HEALTHY OPTIONS:** The name of the Washington State, Health and Recovery Services Administration's managed care program.

**MANAGED CARE:** A prepaid comprehensive system of medical and health care delivery provided through a designated health care plan which is contracted with HRSA.

**MEDICALLY NEEDY (MN):** A federal and state funded Medicaid Program for aged, blind, or persons with disabilities, as well as pregnant women, children, and refugees. It provides slightly less medical coverage than CN, for those with income and/or resources above CN limits.

**TANF:** The Temporary Assistance for Needy Families program offering cash and other benefits to families in need.

**WORKFIRST:** Washington State's Welfare to Work program for federal TANF legislation. It replaced the former AFDC program.

## FAMILY PROGRAMS

### TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (F01)) and FAMILY MEDICAL PROGRAM (F04):

This program provides aid to children and adult(s) who care for them. Families with eligible dependent children under the age of 19, whose income and resources are below TANF limits may receive both TANF cash benefits and CN medical. TANF cash benefits are restricted to 60 months maximum in a lifetime. **A family may choose to only receive CN medical to save TANF eligibility months.**

In determining net income, we deduct 50% of the family's earnings, actual child care costs, and child support paid out by the family.

### INCOME LIMITS

#### *TANF Families With Dependent Children and Family Medical Program*

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT
1	\$349
2	\$440
3	\$546
4	\$642
5	\$740
6	\$841
7	\$971
8	\$1075

**RESOURCES:** For medical eligibility, a family may have \$1,000 in resources at the time of application. Once a family is eligible, there is no resource test for families who only receive medical.

**MEDICAL EXTENSION BENEFITS (MEB, F02, F03):** There are two medical extension benefit programs, sometimes called Transitional Medical Assistance (TMA). In one program, (F02), families are eligible for up to 12 months of extended CN medical benefits, when earned income increases above program standards. A premium is charged to all non-pregnant adults during the second six-months, if the family's countable income is over 100% of the FPL. American Indians/Alaska Natives are exempt from premium payments

In the other program, (F03), families are eligible for up to 4 months of extended CN medical benefits when their cash benefits have been terminated because of increased child support.

**SPECIAL SITUATIONS:** Clients who are **not** eligible for cash benefits **but are eligible** for medical coverage include:

- Persons who are not cooperating with WorkFirst activities;
- Teen parents who are not in an approved living situation or are not meeting school requirements;
- Persons who have reached the 60-month TANF cash benefit limit;
- Other behavioral restrictions.

**STATE FAMILY ASSISTANCE (SFA):** SFA is the state-funded cash program for legal immigrant families who do not meet the eligibility requirements for the federal programs due to citizenship or immigration status. Families on SFA are encouraged to apply for Basic health by calling 1-800-826-2444.

## PREGNANCY AND WOMEN'S HEALTH

The CN medical program for low-income pregnant women, (P02), has no resource limit and the income limits are based on 185 percent of the Federal Poverty Level (FPL). The pregnant woman can be eligible at any time during her pregnancy. Once eligible, the woman continues to be eligible throughout the pregnancy and postpartum period regardless of changes in income.

To determine the pregnant woman's family size, count the pregnant woman and add one for each verified unborn.

EXAMPLE: A woman who verifies she is pregnant with twins is considered to be a three-person family.

*Effective April 1, 2006:*

NUMBER OF PEOPLE	CN MONTHLY INCOME LIMIT*
1	NA
2	\$2,035
3	\$2,560
4	\$3,084
5	\$3,608
6	\$4,132
7	\$4,656
8	\$5,180
<i>Add \$503 for each additional household member</i>	

\* Pregnant women with income above 185 percent FPL may be eligible for the MN program.

**CASH ASSISTANCE FOR PREGNANT WOMEN (P01):** TANF cash benefits are available to pregnant women. Eligible women receive full scope medical coverage under CN.

**NON CITIZEN PREGNANT WOMEN (P04):** Pregnant women are eligible for CN scope of care under the non-citizen pregnant women's program if they are not eligible for Medicaid because of citizenship or immigration status. This includes undocumented women. People receiving benefits under P04 are eligible for the postpartum extension, but are not eligible for the P05 family planning extension.

**POSTPARTUM EXTENSION (no separate program identifier):** The postpartum extension provides full scope medical coverage for women who receive medical benefits at the time their pregnancy ends. These funds provide continued medical coverage through the end of the month which contains the 60th pregnancy ends. (e.g., pregnancy ends June 10, medical benefits continue through August 31). Women receive this extension regardless of how the pregnancy ends.

**FAMILY PLANNING EXTENSION (P05):** The family planning extension provides an additional 10 months of medical coverage after pregnancy to citizen and qualified alien women for family planning services only. Women receive this extension regardless of how the pregnancy ends. The extension follows the postpartum coverage for eligible women who received medical benefits for the pregnancy.

**BREAST AND CERVICAL CANCER Treatment Coverage (S30):** This program provides medical coverage for women who have been diagnosed with breast or cervical cancer or a related pre-cancerous condition. To be eligible, a woman must be identified as needing treatment through the Department of Health's (DOH) Breast and Cervical Health Program (BCHP) or by the Breast and Cervical Early Detection program funded by the Centers for Disease Control. Income and resource eligibility is established by the DOH screening program. Coverage continues throughout treatment for the condition.

**A woman is eligible if she:**

- Is under age 65;
- Has been screened by the BCHP or the CDC-funded program;
- Requires treatment for breast or cervical cancer; and
- Does not have other insurance.

For more information see the Department of Health Web site at <http://www.doh.wa.gov/wbchp/default.htm>

## TAKE CHARGE

**TAKE CHARGE (P06):** A Family Planning program for both women and men that began in July 2001. The program covers pre-pregnancy family planning services, helping participants take charge of their lives before an unintended pregnancy occurs.

**Both women and men may be eligible if:**

- Their family income is at or below 200 percent of FPL; and
- They do not have health insurance coverage; or
- Their current health insurance coverage does not fully cover comprehensive family planning benefits.

*Effective April 1, 2006:*

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT*
1	\$1,634
2	\$2,200
3	\$2,767
4	\$3,334
<i>Add \$544 for each additional household member</i>	

**TAKE CHARGE covers:**

- Annual examination;
- Family planning education and risk reduction counseling;
- FDA-approved contraceptive methods including; birth control pills, IUDs and emergency contraception;
- Over the counter contraceptive products such as condoms and contraceptive creams and foams; and
- Sterilization procedures.

Services are accessed through local clinics, doctors' offices and pharmacies that are participating in TAKE CHARGE. For a list of providers by area call the toll-free Family Planning Hot Line at 1-800-770-4334. Additional information can be found on the DSHS Web site at <http://maa.dshs.wa.gov/familyplan>.

## CHILDREN'S PROGRAMS

**CATEGORICALLY NEEDY (CN):** for newborns (F05).

Newborns are automatically eligible for CN coverage for 12 months if their mother received medical benefits at the time of the child's birth. There are no income or resource limits.

**CN FOR CHILDREN UNDER AGE 19 (F06):** This CN program for citizen and qualifying alien children has no resource limits and the income limits are based on 200 percent of the Federal Poverty Level (FPL). Living with a parent/guardian is not a requirement for eligibility in this program.

*Effective April 1, 2006:*

NUMBER OF PEOPLE	CN MONTHLY INCOME LIMIT - 200% FPL
1	\$1,634
2	\$2,200
3	\$2,767
4	\$3,334
5	\$3,900
6	\$4,467
7	\$5,034
8	\$5,600
<i>Add \$567 for each additional household member</i>	

**State Children's Health Insurance Program (SCHIP, F07):** SCHIP is a federal/state program that covers citizen and qualifying alien children under age 19 in families whose income is too high for Medicaid, but below 250% FPL. To be eligible for SCHIP a child:

1. Cannot be eligible for Medicaid;
2. Cannot be covered by other creditable insurance; and
3. Must pay monthly premiums to the department.

SCHIP has the same scope of coverage as the Categorically Needy program (CN).

*Effective April 1, 2006:*

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT - 200-250% FPL
1	\$2,042
2	\$2,750
3	\$3,459
4	\$4,167
5	\$4,875
6	\$5,584
7	\$6,292
8	\$7,000
<i>Add \$680 for each additional household member</i>	

Children with income above 250% of FPL may be eligible for the MN program.

## CHILDREN'S PROGRAMS CONTINUED

**CHILDREN'S HEALTH PROGRAM (F08):** The Children's Health Program (CHP) is a state-funded program that covers children who are ineligible for other medical programs only because of citizenship or immigration issues. CHP is a capped program, meaning the program is limited to a certain number of people, so there is often a waiting list for entry into the program. There is no resource limit for CHP and family income is limited to 100% of the Federal Poverty Level (FPL).

*Effective April 1, 2006:*

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT - 100% FPL
1	\$817
2	\$1,100
3	\$1,384
4	\$1,667
5	\$1,950
6	\$2,234
7	\$2,517
8	\$2,800
<i>Add \$284 for each additional household member</i>	

**MEDICALLY NEEDY FOR CHILDREN (F99):** Children in families with income over the CN standard may be eligible for MN benefits after incurring medical costs equal to the amount of family income that is above the standard. The program identifier on the Medical ID card is F99. For more explanation of Medically Needy benefits, please see that section of this publication.

**FOSTER CARE/ADOPTION SUPPORT (D01, D02):** Children receiving foster care or adoption support services may be eligible for CN medical benefits through this program. The program is run through the child's foster care or adoption support case worker.

## REFUGEES AND ALIENS

**REFUGEES (R01, R02, R03):** Under the 100 percent federally-funded Refugee Program, a person who has been granted asylum in the U.S. as a refugee or asylee may receive cash benefits for a maximum of eight months. These persons automatically receive Categorically Needy (CN) medical services. Immediately after entering the U.S., families and single refugees are eligible for this program.

Refugees/asylees who have income above cash grant limits may be eligible for the Medically Needy (MN) program for a maximum of eight months, as described above, when they spend down excess income. Income and resource limits are the same as for MN recipients.

Refugees/asylees who have been in the United States for more than eight months are determined eligible for medical benefits the same as U.S. citizens.

**ALIEN EMERGENCY MEDICAL (AEM, F09, L04, S07):** Is a federally funded program for non-citizen aliens with emergent medical conditions. A qualifying emergency medical condition is described in WAC 388-500-0005. The person must be categorically related to a Medicaid program (e.g., a parent with a dependent child, an adult with a disability, or a child under age 19), but are ineligible for Medicaid due to citizenship or alien status. Persons eligible for AEM can receive medical benefits related to the emergent condition only. Income and resource limits are the same as for the program to which they are related, i.e., CN or MN.

- The CSO may need to refer a case to Health and Recovery Services Administration (HRSA), Division of Disability Determination Services to determine a client's disability.
- The CSO may need to refer a case to an HRSA Medical Consultant to decide if the client has an emergent medical condition.
- Persons eligible for AEM can receive medical benefits for the emergent condition and related services only and prior authorization is required for some services.
- Income and resource limits are the same as for the program to which they are related, i.e., CN or MN.

AEM cases have a three month certification period. Transplants, prenatal, and school-based services are not covered under this program.

## AGED, BLIND, AND PERSONS WITH DISABILITIES

### SSI-RELATED MEDICAL COVERAGE

**SSI Related (S02):** Persons who:

- Are 65 years old or older (aged),
- Meet Social Security Administration's definition of blind, or
- Have disabilities, may be eligible for Categorically Needy (CN) medical benefits if their income and resources are the same or lower than the standards for SSI.

*Effective January 1, 2006:*

NUMBER OF PERSONS	RESOURCE LIMIT	INCOME LIMIT
1	\$2,000	\$603.00
2	\$3,000	\$904.00

People with income and/or resources above the standards may be eligible for the Medically Needy (MN) (S95, S99) program.

**SSI-eligible clients (S01):** Persons who receive federal cash benefits under the Supplemental Security Income (SSI) program also receive CN medical coverage automatically. The federal Social Security Administration (SSA) administers the SSI program. The SSI income standard is the Federal Benefit Rate (FBR).

## HEALTHCARE FOR WORKERS WITH DISABILITIES

**HEALTHCARE FOR WORKERS WITH DISABILITIES (HWD, S08)** is a CN medical program that recognizes the employment potential of people with disabilities. Under HWD, people with disabilities (age 16 through 64) can earn more money and purchase healthcare coverage for an amount based on a sliding income scale.

***HWD has no asset test and the net income limit is based on 220 percent of the Federal Poverty Level (FPL)***

*Effective January 1, 2006:*

NUMBER OF PEOPLE	INCOME LIMIT – 220% FPL
1	\$1,797
2	\$2,420

To be eligible, a person must meet federal disability requirements, be employed (including self-employment) full or part time and pay a monthly premium based on the following formula.

**Cost of enrollment:**

To receive HWD benefits, enrollees pay a monthly premium determined from a percentage of their income. American Indian and Alaska Natives are exempt from paying premiums for HWD.

## LONG-TERM CARE (LTC)

**LONG-TERM CARE (LTC) (Community Options Program Entry System (COPEs) – C01, Hospice – C01, C95, C99, Family LTC – K01, K95, K99, Nursing Facility LTC – L01, L02, L95, L99):** LTC services are federally matched programs that fit individual needs and situations. Home and Community-Based (HBC) services enable some people to continue living in their homes with assistance to meet their physical, medical, and social needs. When these needs cannot be met at home, nursing facility care is available.

Income limits for LTC programs vary depending on the services needed, living situation, and marital status. Some income may be allocated to a spouse and any dependents in the home. The client living at home keeps some income for home maintenance and personal needs. If the client is living in a residential setting, such as an adult family home, adult residential care, or assisted living facility (ALF), the amount of income kept depends upon the particular services received. The client who is living in a nursing facility (NF) keeps a small personal needs allowance (PNA) for clothing and incidental expenses. All remaining income is paid toward the cost of care; this is called “participation.”

Resource limits also vary depending on marital status and other factors. All resources of both spouses are considered together. Certain resources are “excluded,” such as household goods and personal effects, a car, home equity (with some exceptions) and life insurance with a face value not more than \$1,500. Most burial plots and prepaid, revocable burial plans not exceeding \$1,500, or irrevocable burial plans are also excluded and not counted toward the resource limits.

A Community Spouse (CS) is allowed to keep resources according to the spousal impoverishment legislation. The Institutional Spouse (IS) is allowed to keep the same resources indicated in the following table for Aged, Blind, and Persons with disabilities.

A different income standard is used to determine eligibility for categorically needy (CN) or medically needy (MN) coverage for LTC services. The standard is 300 percent of the FBR and is called the Special Income Level (SIL). If gross income is at or below the SIL, CN eligibility for either NF or HCB services, such as COPEs may be approved. If income is above the SIL, MN eligibility may be approved with a spenddown only for NF services. Different rules are used when determining eligibility and participation when both spouses receive LTC services. The local Home and Community Services worker can provide this information as needed.

*Effective April 1, 2006:*

INSTITUTIONAL STANDARDS	INCOME LIMIT
Medicaid SIL	\$1,809.00
PNA GA-U/GA-X	\$41.62
PNA NF/hospital	\$51.62
PNA state veterans home	\$160.00
PNA single veteran	\$90.00
COPEs maintenance w/o community spouse	\$817.00
COPEs maintenance with community spouse	\$603.00
COPEs maintenance in ALF	\$603.00
Housing maximum	\$817.00
Community Spouse Maintenance	\$2,489.00
Community spouse income and family allocation	\$1,604.00
Community spouse excess shelter allowance	\$481.00
Utility standard	\$326.00
Spousal resource maximum	\$41,943 up to \$99,540
Statewide monthly private nursing home rate	\$5,763.00

## MEDICARE SAVINGS PROGRAMS

DSHS may pay the Medicare premiums for certain clients who are aged, blind, and have disabilities. These programs have higher income and resource limits.

**QUALIFIED MEDICARE BENEFICIARY (QMB, S03):** The client must be entitled to, or enrolled in, Medicare Part A. Income limits are based on 100 percent of the Federal Poverty Level (FPL). Under QMB, DSHS pays for Medicare Part A premiums if not free and Medicare Part B premiums, deductibles, co-payments, and may pay for Medicare Part C (HMO premiums).

**SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB, S05):** The client must be entitled to, or enrolled in, Medicare Part A. Income limits are over 100 percent of the Federal Poverty Level (FPL) but under 120 percent of the FPL. Under SLMB, DSHS pays the client's Medicare Part B premium **only**.

**QUALIFIED INDIVIDUAL (QI-1, S06):** The client must have applied for, or enrolled in, Medicare Part B and not be eligible for any other Medicaid coverage. Income limits are from 120 percent but under 135 percent of the FPL. Under QI-1, DSHS pays the client's Medicare Part B premium **only**.

**QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI, S04):** The client must be entitled to or enrolled in Medicare Part A; be a working person who has disabilities; has exhausted premium-free Part A; and whose SSA disability benefits ended because the client's earnings exceeded SSA's gainful activity limits. Income limits are based on 200 percent of the FPL. DSHS pays the client's Medicare Part A premium **only**. Individuals considering this program may also benefit from information about the Healthcare for Workers with Disabilities program.

*Effective April 1, 2005:*

MEDICARE SAVINGS PROGRAM	FEDERAL POVERTY LEVEL (FPL)	MONTHLY INCOME LIMIT ONE PERSON	MONTHLY INCOME LIMIT TWO PERSONS
QMB	100%	\$817	\$1,100
SLMB	120%	\$980	\$1,320
QI-1	135%	\$1,103	\$1,485
QDWI	200%	\$1,634	\$2,200
Resource Limit	N/A	\$4,000	\$6,000

People eligible for Medicare have limited Medicaid prescription drug coverage.

## MEDICALLY NEEDY (MN) AND SPENDDOWN

**MEDICALLY NEEDY (all letter codes with 95 or 99 after the letter):** Medically Needy (MN) is a federal and state funded Medicaid program for persons who are aged, blind, or have disabilities, pregnant women, children and refugees with income above Categorically Needy (CN) limits. It provides slightly less medical coverage than CN, and requires greater financial participation by the client.

MN clients with income above MN limits are required to spend down excess income before medical benefits can be authorized. The client spends down the excess by incurring financial obligations for medical expenses equal to the spenddown amount. **The client is responsible for paying these medical expenses.**

*Effective January 1, 2006:*

NUMBER OF PEOPLE	MN RESOURCE LIMIT	MN MONTHLY INCOME LIMIT
1	\$2,000	\$603
2	\$3,000	\$603
3	\$3,050	\$667
4	\$3,100	\$742
5	\$3,150	\$858
6	\$3,200	\$975
7	\$3,250	\$1,125
8	\$3,300	\$1,242
9	\$3,350	\$1,358
10	\$3,400	\$1,483
10+	+\$50/Person	Maximum \$1,483

**SPENDDOWN:** Spenddown is like an insurance deductible. It is the process through which the client uses excess income to pay for the cost of medical care. Clients must incur medical expenses equal to their excess income (spenddown liability) before medical benefits can be authorized. The spenddown liability is the client's financial obligation and cannot be paid by the state. The amount of the client's spenddown is computed using a base period, consisting of three or six consecutive calendar months. Depending on when spenddown is met, the client may get medical benefits for all or part of the base period.

**SPENDDOWN EXAMPLE:** Applicant is a single woman, age 67. She receives \$650 Social Security benefits each month and has \$1,000 in savings. The client's \$1,000 resources are below the resource limit of \$2,000, so she is resource eligible. Her income is above MN income limits, but MN allows spenddown of excess income. She is eligible for MN when she meets spenddown.

SSA benefits (less \$20 general disregard* \$650 – \$20)	\$630
<u>Less MN income limit</u>	<u>– \$603</u>
Excess income	= \$27

The client can choose between a three-month or a six-month base period on her amount of spenddown and the amount of medical bills she expects. She will have to incur either \$81 (\$27 times 3 months) or \$162 (\$27 times 6 months) medical expenses before she is eligible for MN. This is her spenddown amount. She will be responsible for these expenses; HRSA will pay for her covered medical expenses after she meets spenddown.

\* General Disregard: The federal government allows \$20 of the client's income to be disregarded when determining income limits.

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## GENERAL ASSISTANCE

**MEDICAL CARE SERVICES (MCS):** MCS is the state-funded medical program that provides limited medical benefits to persons eligible for Alcohol and Drug Addiction and Treatment and Support Act program (ADATSA) and General Assistance-Unemployable (GA-U) cash assistance. Income and resource limits are the same as for family CN medical programs. MCS does not cover out-of-state medical care.

**GENERAL ASSISTANCE–UNEMPLOYABLE (GA-U, S01):** GA-U is a state-funded program that provides cash benefits for persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. Medical benefits are paid through MCS.

**GENERAL ASSISTANCE–EXPEDITED MEDICAID DISABILITY (GA-X, G02):** The GA-X program provides state-funded cash assistance and full scope CN medical benefits to persons who appear to meet the SSI disability criteria. Contracted doctors make the decision whether clients meet this criteria.

**GA-U IMMIGRANTS:** Immigrants determined to meet eligibility requirements for GA-U are eligible for state-funded Medical Care Services.

**GENERAL ASSISTANCE FOR ALCOHOL AND DRUG TREATMENT (ADATSA, GA-W, W01, W02, W03):** ADATSA is the state-funded program that provides shelter and/or medical benefits, treatment, and support for persons incapacitated from gainful employment due to drug or alcohol abuse. Eligible persons receive limited medical coverage through MCS. Only medical is available to persons waiting to get into treatment.

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## PSYCHIATRIC INDIGENT INPATIENT PROGRAM (PII)

Mental Health Division (MHD) created the PII (M99) program to ensure eligible clients receive continued psychiatric inpatient hospital services. The program funds voluntary community psychiatric inpatient hospital care for indigent clients who qualify.

Important: The maximum length of certification for PII is three months in any 12-month period.

Income and resource limits for the PII program are the same as for MN. Clients with excess income and/or resources above the MN limits must spend down the excess before they are eligible for PII.

The PII program pays only for emergent inpatient psychiatric care in community hospitals within the state of Washington. Psychiatric indigent inpatient (PII) does not cover ancillary charges for physician, transportation, pharmacy or other costs associated with a voluntary inpatient psychiatric hospitalization. For more information, contact Christina Winans at Mental Health Division, (360) 902-0844; email: [winanca@dshs.wa.gov](mailto:winanca@dshs.wa.gov).

HRSA Provider memo 03-16 can be seen at:

<http://fortress.wa.gov/dshs/maa/Download/Memos/2003Memos/03-16maa.pdf>

Involuntary psychiatric hospitalizations (commitments) are authorized under the Involuntary Treatment Act (ITA), RCW 71.05 and RCW 71.34. Generally, there is no change in how ITA cases are handled. For those who are not eligible for medical assistance, hospitals continue to use existing procedures to bill ITA cases. That process is separate and apart from the Psychiatric Indigent Inpatient (PII) program.

**EMERGENCY MEDICAL EXPENSE REQUIREMENT (EMER):** PII requires \$2,000 EMER (Emergency Medical Expense Requirement) per family for each continuous 12-month period before a family member can be eligible for the program. The EMER is comparable to a deductible on an insurance policy. An applicant can meet this requirement with voluntary inpatient psychiatric hospitalization **only**.

## MEDICAL ID CARD

Persons who receive medical coverage get a Medical ID card each month. It is sometimes called a Medical Coupon or MAID.

Sample Medical ID Card (Medical Coupon)

Please read the back of this card.

**1** PO BOX 45893  
OLYMPIA WA 98504-5893

**2** MEDICAL IDENTIFICATION CARD  
**3** This Card Valid From: 08/01/2004  
**4** S01 To: 08/31/2004

Patient Identification Code (PIC)				Medical Coverage Information											
Initials	Birthdate	Last Name	ID	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other				
M-	010143	L1MAB	A												
<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>				
<b>18</b> MARJORIE LIMA BEANS #5L 515 WASHINGTON ST VANCOUVER WA 98660-3456				<b>19</b> CNP <b>20</b> <b>21</b> <b>22</b> XXX XXXXXXXXXX <b>23</b> XXXXXXXXXX											

SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE  
DSHS 13-030(x)ACES(4/95)

**24** NOT TRANSFERABLE  
SIGNATURE (not valid unless signed)

XXXXXXXX XXXXXX - X

The codes below are the medical coverage group found in field 4 on the coupon. These codes identify the type of medical assistance the patient is receiving. Identification of medical coverage group helps providers to determine the need for additional services such as pregnancy-related First Steps services or if the patient is potentially a Healthy Options enrollee.

Medical Coverage Group Codes – Field 4	Medical Coverage Group Definitions
C01, C95, and C99	Waiver and Home and Community Based Programs such as COPES, DDD Waivers, OBRA and Hospice
D01, D02	Foster Care, Adoption Support, and Juvenile Rehabilitation Services
F01, F02, F03, F04, and F09	Family Medical
F05, F06, F95, and F99	Children's Medical
F07	CHIP
F08	Children's Health Program
G01 and G02	General Assistance
G03, G95, and G99	Medical Assistance for a resident of Alternate Living Facility (ALF)
I01	Institution for the Mentally Diseased (IMD)
K01, K03, K95, and K99	Long Term Care – Families
L01, L02, L04, L95, and L99	Long Term Care – Aged, Blind, Disabled
M99	Psychiatric Indigent Inpatient (PII)
P02, P04, and P99	Pregnancy related
P05	Family Planning only
P06	Take Charge Family Planning
R01 R02, and R03	Refugee
S01, S02, S07, S95, and S99	Aged, Blind, or Disabled (SSI and SSI related)
S30	Breast and Cervical Cancer Treatment
S03, S04, S05, S06	Medicare savings programs
S08	Health Care for Workers with Disabilities (HWD)
W01, W02 and W03	ADATSA

## KEY TO MEDICAL ID CARD

## AREA DESCRIPTION

- 1 Address of CSO.
- 2 Date eligibility begins.
- 3 Date eligibility ends.
- 4 Medical coverage group described in the table on the previous page.

## Patient Identification Code (PIC) Segments Are:

- 5 First and middle initials (*or a dash (-) if the middle initial is not known*).
- 6 Six-digit birth date, consisting of numerals only (*MMDDYY*).
- 7 First five letters of the last name (*and spaces if the name is fewer than five letters*).
- 8 Tie breaker (*an alpha or numeric character*).

## Medical Coverage Information

- 9 **Insurance carrier code** - A four-character alphanumeric code (*insurance carrier code*) in this area indicates the private insurance plan information.
- 10 **Medicare** - Xs indicate the client has Medicare coverage.
- 11 **HMO** (*Health Maintenance Organization*) – Alpha code indicates enrollment in an HRSA Healthy Options managed health care plan. (***Managed health care plan is the same as HMO***). This area may also contain the legend PCCM (*primary care case manager*). The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in Healthy Options: F01, F02, F03, F04, F05, F06, F07, and P02.
- 12 **Detox** - Xs indicate eligibility for a 3-day alcohol or a 5-day drug detoxification program.
- 13 **Restrictions** - Xs indicate the client is assigned to one physician and one pharmacist. The words “client on review” in Field 20 will also indicate restricted clients.
- 14 **Hospice** - Xs indicate the client has elected hospice care.
- 15 **DD client** - Xs indicate this person is a client of the DSHS Division of Developmental Disabilities.
- 16 **Other** - This area is not in use.
- 17 **HIC** shows an indicator for a Medicare claim number.
- 18 **Name** and address of client, head of household or guardian.
- 19 **Medical program** and scope of care indicators.
- 20 **Other messages** (*e.g., client on review, delayed certification, emergency hospital only*).
- 21 **Telephone number and name** of PCCM or Healthy Options plan.
- 22 **Local field office** (*3 digits*) and ACES assistance unit # (*9 digits*).
- 23 **Internal control numbers** for DSHS use only.
- 24 **Client's signature** - May be used to verify identity of client.
- 25 **Client's primary language**.

## COVERED SERVICES

HRSA provides a wide range of medical services. Not all eligibility groups receive all services. Coverage is broadest under the Categorically Needy (CN) program.

The table below lists major services that are available to clients by program: CN (Categorically Needy), MN (Medically Needy), and MCS (Medical Care Services for GAU and ADATSA).

SERVICE	CN <sup>1</sup>	MN	MCS
Adult Day Health	Yes	No	Yes
Advanced RN Practitioner Services	Yes	Yes	Yes
Ambulance/Ground and Air	Yes	Yes	Yes
Anesthesia Services	Yes	Yes	Yes
Audiology	Yes	HK	Yes
Blood/Blood Administration	Yes	Yes	Yes
Case Management - Maternity	L	L	No
Chiropractic Care	HK	HK	No
Clinic Services	Yes	Yes	Yes
Community Mental Health Centers	Yes	Yes	L <sup>3</sup>
Dental Services	Yes	Yes	R
Dentures Only	Yes	Yes	No
Detox Alcohol (3 days)	Yes	Yes	Yes
Detox Drugs (5 days)	Yes	Yes	Yes
Drugs and supplies, prescription*	Yes	Yes	Yes
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Yes	Yes	No
Elective Surgery	Yes	Yes	Yes
Emergency Room Services <sup>7</sup>	Yes <sup>7</sup>	Yes <sup>7</sup>	Yes <sup>7</sup>
Emergency Surgery	Yes	Yes	Yes
Eyeglasses and Exams	Yes	Yes	Yes
Family Planning Services <sup>4</sup>	Yes	Yes	Yes
Hearing Aid	L	L	L
Home Health Services	L	L	L
Hospice	Yes	Yes	No
Indian Health Clinics	Yes	Yes	No
Inpatient Hospital Care	Yes	Yes	Yes
Involuntary Commitment	Yes	Yes	Yes
Maternity Support Services	Yes	Yes	No
Medical Equipment	Yes	Yes	Yes
Neuromuscular Centers	Yes	Yes	No
Nursing Facility Services	Yes	Yes	Yes
Nutrition Therapy	HK	HK	No
Optometry	Yes	Yes	Yes
Organ Transplants	Yes	Yes	Yes
Orthodontia	L	L	No
Out-of-State Care	Yes	Yes	No
Outpatient Hospital Care	Yes	Yes	Yes
Oxygen/Respiratory Therapy	Yes	Yes	Yes

## Covered Services Continued

SERVICE	CN <sup>1</sup>	MN	MCS
Pain Management (Chronic)	Yes	Yes	Yes
Personal Care Services	Yes	HK	No
Physical/Occupational/Speech Therapy	Yes	L <sup>5</sup>	Yes
Physical Medicine and Rehab	Yes	Yes	Yes
Physician	Yes	Yes	Yes
Podiatry	Yes	Yes	Yes
Private Duty Nursing	L	L	L
Prosthetic Devices & Mobility Aids	Yes	Yes	Yes
Psychiatric Services	Yes	Yes	No
Psychological Evaluation	L	L	L
Rural Health Services & FQHC	Yes	Yes	Yes
School Medical Services <sup>2</sup>	Yes	Yes	No
Substance Abuse/Outpatient	Yes	Yes	No <sup>6</sup>
Total Enteral/Parenteral Nutrition	Yes	Yes	Yes
Transportation Other Than Ambulance	Yes	Yes	Yes
X-Ray and Lab Services	Yes	Yes	Yes

**KEY:**

- Yes** Service is covered (may require prior approval or have other requirements)
- No** Service is not covered
- HK** Coverage limited to Healthy Kids / EPSDT program only (health checkup and treatment program for children under 21)
- L** Limited coverage
- R** Restricted to emergency medical conditions

\* People eligible for Medicare are limited to prescriptions that are excluded from Medicare coverage.

- 1 Includes all CN programs, and services available to non-citizen women on the Pregnancy Program (P04).
- 2 A program for Medicaid children in school Special Education Programs.
- 3 Clients must meet the priorities and definitions of the Community Mental Health Act. Limited grants to counties fund these services.
- 4 All clients covered under all medical care programs receive family planning services. Citizen and qualified alien women eligible for medical care during pregnancy receive family planning services only up to 12 months after pregnancy ends.
- 5 When the client is receiving home health care services.
- 6 Paid for out of ADATSA funds.
- 7 Three dollar copays will be charged to non-pregnant adults who use the emergency room for services that are not related to an emergency medical condition. American Indian/Alaska Native (AI/AN) are exempt from paying a co-payment.





## **C u s t o m e r   T o l l - F r e e   N u m b e r s**

Basic Health Plan.....	1-800-826-2444
HRSA Customer Service Center (Clients).....	1-800-562-3022
7 am-7 pm, Monday-Friday	
TTY/TDD users only.....	1-800-848-5429
Medical Eligibility Determination Services (MEDS) .....	1-800-204-6429
TTY/TDD users only.....	1-800-204-6430
Pharmacy Authorization.....	1-800-848-2842
Provider Enrollment .....	1-866-545-0544
8 am-4:30 pm, Monday-Friday, 10 am-4:30 pm Wednesday	
Provider Inquiry .....	1-800-562-6188
Third Party Resource Hotline (Coordination of Benefits).....	1-800-562-6136

## **U s e f u l   W e b   A d d r e s s e s**

Basic Health Plan .....	<a href="http://www.basichealth.hca.wa.gov/">http://www.basichealth.hca.wa.gov/</a>
DSHS Rules .....	<a href="http://www.leg.wa.gov/wac/">http://www.leg.wa.gov/wac/</a>
(Washington Administrative Code)	
Economic Service Administration.....	<a href="https://wvs2.wa.gov/dshs/onlinecso">https://wvs2.wa.gov/dshs/onlinecso</a>
(For locating your CSO or applying for assistance (including on-line) etc.	
Eligibility A-Z Manual .....	<a href="http://www1.dshs.wa.gov/esa/eazmanual/default.htm">http://www1.dshs.wa.gov/esa/eazmanual/default.htm</a>
HRSA Billing Instructions .....	<a href="http://fortress.wa.gov/dshs/maa/rbrvs/rbrvs.htm">http://fortress.wa.gov/dshs/maa/rbrvs/rbrvs.htm</a>
HRSA Internet .....	<a href="http://fortress.wa.gov/dshs/maa/">http://fortress.wa.gov/dshs/maa/</a>
HRSA Intranet .....	<a href="http://imaa.dshs.wa.gov/default.aspx">http://imaa.dshs.wa.gov/default.aspx</a>
HRSA Numbered Memos .....	<a href="http://fortress.wa.gov/dshs/maa/download/Numberedmemos.html">http://fortress.wa.gov/dshs/maa/download/Numberedmemos.html</a>
Washington State Law (RCW's) .....	<a href="http://apps.leg.wa.gov/rcw/">http://apps.leg.wa.gov/rcw/</a>

